

STATE OF ILLINOIS

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Facility Name & ID Number PINE ACRES CARE CENTER# 0039289 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>119</u>	Skilled (SNF)	<u>119</u>	<u>43,554</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>119</u>	TOTALS	<u>119</u>	<u>43,554</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>11,361</u>	<u>8,862</u>	<u>1,844</u>	<u>22,067</u>	8
9	SNF/PED					9
10	ICF	<u>4,426</u>	<u>8,940</u>		<u>13,366</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,787</u>	<u>17,802</u>	<u>1,844</u>	<u>35,433</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.35%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 03/01/1994

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 03/01/1997 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 8 and days of care provided 1,779Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2000 Fiscal Year: 06/30/2000

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number

PINE ACRES CARE CENTER

0039289

Report Period Beginning:

07/01/1999

Ending:

06/30/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	251,886	11,706	18,676	282,268	696	282,964		282,964		1
2	Food Purchase		219,352		219,352	(1,124)	218,228	(8,658)	209,570		2
3	Housekeeping	115,628	23,139		138,767		138,767		138,767		3
4	Laundry		22,296	90,462	112,758		112,758		112,758		4
5	Heat and Other Utilities			93,455	93,455		93,455		93,455		5
6	Maintenance	53,454	23,017	45,760	122,231		122,231		122,231		6
7	Other (specify):*										7
8	TOTAL General Services	420,968	299,510	248,353	968,831	(428)	968,403	(8,658)	959,745		8
	B. Health Care and Programs										
9	Medical Director			5,726	5,726		5,726		5,726		9
10	Nursing and Medical Records	1,363,435	214,860	147,826	1,726,121	(104,589)	1,621,532		1,621,532		10
10a	Therapy	65,346	1,460	116,454	183,260		183,260		183,260		10a
11	Activities	61,166	8,186	13,944	83,296	16,043	99,339		99,339		11
12	Social Services	15,074		6,398	21,472		21,472		21,472		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,505,021	224,506	290,348	2,019,875	(88,546)	1,931,329		1,931,329		16
	C. General Administration										
17	Administrative	68,752			68,752	45,510	114,262	155,031	269,293		17
18	Directors Fees										18
19	Professional Services			142,865	142,865	(83,081)	59,784	73	59,857		19
20	Dues, Fees, Subscriptions & Promotions			27,149	27,149	465	27,614	(5,488)	22,126		20
21	Clerical & General Office Expenses	106,705	20,779	46,169	173,653	2,186	175,839	15,507	191,346		21
22	Employee Benefits & Payroll Taxes			517,901	517,901	10,841	528,742	41,725	570,467		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,120	2,120	591	2,711	2,678	5,389		24
25	Other Admin. Staff Transportation			1,603	1,603	3,343	4,946	2,974	7,920		25
26	Insurance-Prop.Liab.Malpractice			15,539	15,539		15,539		15,539		26
27	Other (specify):*										27
28	TOTAL General Administration	175,457	20,779	753,346	949,582	(20,145)	929,437	212,500	1,141,937		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,101,446	544,795	1,292,047	3,938,288	(109,119)	3,829,169	203,842	4,033,011		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number **PINE ACRES CARE CENTER**

#0039289

Report Period Beginning: 07/01/1999 Ending: 06/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			218,004	218,004		218,004	(50,916)	167,088			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			177,554	177,554		177,554	(6,020)	171,534			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					1,548	1,548		1,548			34
35	Rent-Equipment & Vehicles			5,317	5,317	(5,317)		804	804			35
36	Other (specify):*											36
37	TOTAL Ownership			400,875	400,875	(3,769)	397,106	(56,132)	340,974			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					107,063	107,063		107,063			39
40	Barber and Beauty Shops	19,294	1,132		20,426	4,438	24,864	(95)	24,769			40
41	Coffee and Gift Shops					1,387	1,387		1,387			41
42	Provider Participation Fee			66,153	66,153		66,153		66,153			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	19,294	1,132	66,153	86,579	112,888	199,467	(95)	199,372			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,120,740	545,927	1,759,075	4,425,742		4,425,742	147,615	4,573,357			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number PINE ACRES CARE CENTER

0039289

Report Period Beginning:

07/01/1999

Ending:

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,658)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(50,916)	30		9
10	Interest and Other Investment Income	(6,020)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(95)	40		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,234)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (71,923)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(39,369)	VARIOUS	34
35	Other- Attach Schedule VIII B	258,907	VARIOUS	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 219,538		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 147,615		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops	z		1,387	2	40
41	Barber and Beauty Shops	x		4,438	22	41
42	Laboratory and Radiology		x			42
43	Prescription Drugs	x		107,063	10	43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$ 112,888		47

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PINE ACRES CARE CENTER

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ID# 0039289
Report Period Beginning: 07/01/1999
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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
			Reference
1	INDIRECT COSTS FROM SCHEDULE VIII-B	\$ 155,831	17 1
2	INDIRECT COSTS FROM SCHEDULE VIII-B	39,442	19 2
3	INDIRECT COSTS FROM SCHEDULE VIII-B	746	20 3
4	INDIRECT COSTS FROM SCHEDULE VIII-B	15,507	21 4
5	INDIRECT COSTS FROM SCHEDULE VIII-B	41,725	22 5
6	INDIRECT COSTS FROM SCHEDULE VIII-B	2,678	24 6
7	INDIRECT COSTS FROM SCHEDULE VIII-B	2,974	25 7
8	INDIRECT COSTS FROM SCHEDULE VIII-B	804	25 8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
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84			84
85			85
86			86
87			87
88			88
89			89
90	Total	258,907	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PINE ACRES CARE CENTER

0039289

Report Period Beginning:

07/01/1999

Ending:

06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,658)	0	0	0	0	0	0	0	0	0	0	(8,658)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,658)	0	0	0	0	0	0	0	0	0	0	(8,658)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	155,031	0	0	0	0	0	0	0	0	0	0	155,031	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	39,442	(39,369)	0	0	0	0	0	0	0	0	0	73	19
20	Fees, Subscriptions & Promotions	(5,488)	0	0	0	0	0	0	0	0	0	0	(5,488)	20
21	Clerical & General Office Expenses	15,507	0	0	0	0	0	0	0	0	0	0	15,507	21
22	Employee Benefits & Payroll Taxes	41,725	0	0	0	0	0	0	0	0	0	0	41,725	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	2,678	0	0	0	0	0	0	0	0	0	0	2,678	24
25	Other Admin. Staff Transportation	2,974	0	0	0	0	0	0	0	0	0	0	2,974	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	251,869	(39,369)	0	0	0	0	0	0	0	0	0	212,500	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	243,211	(39,369)	0	0	0	0	0	0	0	0	0	203,842	29

Facility Name & ID Number PINE ACRES CARE CENTER

0039289

Report Period Beginning:

07/01/1999

Ending:

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BENSENVILLE HOME SOCIETY		PEOTONE SENIOR LIVING CENTER	PEOTONE	LIFELINK AREA		INDEPENDENT
LIFELINK CORP. (BHS PARENT)	100	ANCHORAGE OF BEECHER	BEECHER	HOUSING	VARIOUS	LIVING
	100	ANCHORAGE OF BENSENVILLE	BENSENVILLE	BRIDGEWAY OF		INDEPENDENT
				BENSENVILLE	BENSENVILLE	LIVING
				LIFELINK CHARITI	BENSENVILLE	FUND RAISING
				LIFELINK SERVICE	BENSENVILLE	PROJ. DEVEL.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	19	MANAGEMENT FEES	\$ 96,872	LIFELINK CORP. (V.P. OF HEALTH CARE)	100.00%	\$ 60,448	\$ (36,424)	1
2	V	19	MANAGEMENT FEES	15,404	LIFELINK CORP. (PASTORAL CARE)	100.00%	14,210	(1,194)	2
3	V	19	MANAGEMENT FEES	13,046	BHS (VOLUNTEER COORDINATOR)	100.00%	11,423	(1,623)	3
4	V	19	MANAGEMENT FEES	1,314	BHS (INTERGENERATIONAL COORDINATOR)	100.00%	1,186	(128)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 126,636			\$ 87,267	\$ * (39,369)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
15	V		\$			\$	15
16	V						16
17	V						17
18	V						18
19	V						19
20	V						20
21	V						21
22	V						22
23	V						23
24	V						24
25	V						25
26	V						26
27	V						27
28	V						28
29	V						29
30	V						30
31	V						31
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$			\$ 0	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number PINE ACRES CARE CENTER # 0039289 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CARL ZIMMERMAN	PRESIDENT	ADMIN.	NONE	50,779	4.56	11.40	SALARY	\$ 12,543	17-7	1
2	ROBERT LOGSTON	EXEC. VP ADMIN.	ADMIN.	NONE	50,779	4.56	11.40	SALARY	12,543	17-7	2
3	JOAN DI LEONARDI	EXEC. VP OPER.	ADMIN.	NONE	50,779	4.56	11.40	SALARY	12,543	17-7	3
4	JAMES FORMAL	VP HEALTH CARE	ADMIN-HEALTH	NONE	71,500	14	35.00	SALARY	38,500	19-3	4
5	L. MANOR/T. NOESEN	VP FIN/TREASURE	ACCT/FINANCE	NONE	50,779	4.56	11.40	SALARY	12,543	17-7	5
6	M. CARLSON/A. GABRYS	CONTROLLER	ACCT/FINANCE	NONE	31,860	4.56	11.40	SALARY	7,870	17-7	6
7	JATHY LYNN CICERO	VP CORP. SERV.	ADMIN.	NONE	11,969	4.56	11.40	SALARY	2,957	17-7	7
8	KENYETTA HAYWOOD	VP SUPP. SERV.	SUPP. SERV.	NONE	50,779	4.56	11.40	SALARY	12,543	17-7	8
9	PAMELA JONES	DIR. - VOL... SERV.	RECRUIT/PLACM	NONE	25,870	4	10.00	SALARY	3,696	11-7	9
10	DONALD PRIMDAHL	DIR. - BUDGETING	BDGT/GOVT. RE	NONE	33,358	4.56	11.40	SALARY	8,240	17-7	10
11	JANET HISBON	DIR. - PAST. CARE	SPRITUAL SERV	NONE	23,312	4	10.00	SALARY	3,951	11-7	11
12	KATHLEEN SCHUPBACH	DIR. - HUMAN RES.	PERSONNEL	NONE	22,532	4.56	11.40	SALARY	5,566	17-7	12
13								TOTAL	\$ 133,495		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PINE ACRES CARE CENTER # 0039289 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MELODY LEIMNETZER	DIR. - TRAINING	TRAINING	NONE	13,746	4.56	11.40	SALARY	\$ 6,119	17-7	1
2	ROBIN MCBROOM	INTERGEN. COORD.	ACTIVITIES	NONE	3,142	0.8	2.00	SALARY	786	11-7	2
3											3
4								TOTAL PAGE 7	133,495		4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 140,400		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PINE ACRES CARE CENTER# 0039289

Report Period Beginning:

07/01/1999Ending: 6/30/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization LIFELINK CORPORATIONStreet Address 331 S. YORK ROADCity / State / Zip Code BENSENVILLE, IL. 60106Phone Number (630) 766-3570Fax Number (630) 860-5130

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATION	DIRECT PROG. COST	39,065,398	12	\$ 1,359,577	\$ 1,359,577	4,454,569	\$ 155,031	1
2	19	PROFESSIONAL SERVICES	DIRECT PROG. COST	39,065,398	12	345,899		4,454,569	39,442	2
3	20	FEEs, SUBSCRIPTIONS, PROM	DIRECT PROG. COST	39,065,398	12	6,545		4,454,569	746	3
4	21	GEN. OFFICE EXPENSE	DIRECT PROG. COST	39,065,398	12	135,993		4,454,569	15,507	4
5	22	EMP. TAXES & BENEFITS	DIRECT PROG. COST	39,065,398	12	365,915		4,454,569	41,725	5
6	24	TRAVEL & SEMINARS	DIRECT PROG. COST	39,065,398	12	23,482		4,454,569	2,678	6
7	25	OTHER STAFF TRANS.	DIRECT PROG. COST	39,065,398	12	26,084		4,454,569	2,974	7
8	35	RENTAL EQUIP.	DIRECT PROG. COST	39,065,398	12	7,048		4,454,569	804	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,270,543	\$ 1,359,577		\$ 258,907	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	TAX EXEMPT BONDS		X	REFINANCE MORTGAGE			\$	\$			\$	1	
2				& CAPITAL PROJECTS	*	*	*	*	*	*	177,554	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$ 177,554	9	
	B. Non-Facility Related*												
10												10	
11							* SEE ATTACHED					11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ *	\$ *			\$ 177,554	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **PINE ACRES CARE CENTER**# **0039289** Report Period Beginning: **07/01/1999** Ending: **06/30/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	0	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	0	2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	0	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	0	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	0	8
	1996	0	9
	1997	0	10
	1998	0	11
	1999	0	12

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,295
 B. General Construction Type: Exterior BRICK Frame Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	LONG TERM CARE	126,760	1994	\$ 300,000	1
2					2
3	TOTALS	126,760		\$ 300,000	3

Facility Name & ID Number PINE ACRES CARE CENTER# 0039289

Report Period Beginning:

07/01/1999 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		1994	1968	\$ 2,500,000	\$ 100,000	35	\$ 71,429	\$ (28,571)	\$ 452,383	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		1985 ADMIN. BLDG, RENOVATION		1985	197,886	4,947	40	4,947		79,955	9
10		1986 ADMIN. BLDG, RENOVATION		1986	15,248	381	40	381		5,721	10
11		HOT WATER HEATER		1994	3,432	343	10	343		2,088	11
12		WATER CONDITIONER		1994	6,813	681	10	681		4,029	12
13		(5) AIR TERMINAL UNITS		1994	9,375	937	10	937		5,314	13
14		TILE FLOORING FOR ROOMS		1995	9,074	907	8	1,134	227	5,859	14
15		(2) BOILER AIR DAMPERS		1995	28,538	2,854	20	1,427	(1,427)	7,848	15
16		REMODEL COMMON AREA		1995	12,822	1,282	8	1,603	321	8,549	16
17		RUBBER ROOF - KITCHEN		1995	19,134	1,913	10	1,913		10,043	17
18		1.25 HP DISPOSAL		1995	1,093	146	10	109	(37)	618	18
19		MASONRY REPAIR TO EXTERIOR WALLS		1996	5,600	187	30	187		779	19
20		(7) WALL UNITS		1996	8,500	850	10	850		3,683	20
21		RESURFACE PARKING LOT		1996	8,891	889	10	889		3,112	21
22		ROOF REPAIRS		1996	9,620	321	30	321		1,203	22
23		REMODLE ROOMS 121 AND 123		1997	9,985	333	30	333		1,165	23
24		REMODLE FRONT FOYER AND RECEPTION AREA		1997	13,985	466	30	466		1,631	24
25		REMODLE ROOMS 25,26 AND 35		1997	18,530	618	30	618		2,163	25
26		REMODLE BATH AREAS		1997	12,822	1,282	10	1,282		4,487	26
27		REMODLE STAFF LOUNGE		1997	18,635	621	30	621		1,553	27
28		INSTALL GARBAGE ARE ENCLOSURE		1997	4,873	487	10	487		1,421	28
29		INSTALL DOMESTIC WATER		1998	7,800	260	30	260		650	29
30		REPLACE (23) VANITIES W/SINKS		1998	18,500	1,850	10	1,850		4,313	30
31		ROOF ADDITION		1999	88,173	2,939	30	2,939		3,184	31
32		NEW CARPETING		1999	18,018	1,802	10	1,802		2,102	32
33		(9) HEATING / AC WALL UNITS		1999	13,692	1,369	10	1,369		1,483	33
34		NEW CARPETING		1999	2,217	185	10	185		185	34
35		RENOVATE HALLWAY		1999	3,214	321	10	321		321	35
36	TOTAL (lines 4 thru 35)				\$ 3,066,470	\$ 129,171		\$ 99,684	\$ (29,487)	\$ 615,842	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9		Improvement Type**									9
10		HEAT TAPE GUTTERS		1999	1,650	96	10	96		96	10
11		(40) HEAT VALVES FOR BOILER		2000	4,800	200	10	200		200	11
12		(5) HEAT VALVES FOR BOILER		2000	1,660	28	10	28		28	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 8,110	\$ 324		\$ 324	\$	\$ 324	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 617,479	\$ 85,624	\$ 64,195	\$ (21,429)	5-10	\$ 374,486	37
38	Current Year Purchases	46,021	2,885	2,885		5-10	2,885	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 663,500	\$ 88,509	\$ 67,080	\$ (21,429)		\$ 377,371	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43	N/A									43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 4,038,080	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 218,004	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 167,088	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (50,916)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 993,537	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53	N/A				53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	RECONSTRUCT FLOOR	\$ 4,834	58
59			59
60			60
61		\$ 4,834	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ **5,084** Description: **SEE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. **/2001** \$

13. **/2002** \$

14. **/2003** \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	\$		\$	\$ 320		\$ 320	1
2	Licensed Speech and Language Development Therapist	10a	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs				883		883	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 1,203		\$ 1,203	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 26,081	\$ 571,108	1
2	Cash-Patient Deposits		184,448	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 402,960)	591,217	4,670,993	3
4	Supply Inventory (priced at)	16,320	63,961	4
5	Short-Term Investments		452,169	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		226,020	7
8	Accounts Receivable (owners or related parties)	265,821		8
9	Other(specify): GRANTS/CONTRIB. REC		630,840	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 899,439	\$ 6,799,539	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		921,501	13
14	Buildings, at Historical Cost		20,772,709	14
15	Leasehold Improvements, at Historical Cost		550,692	15
16	Equipment, at Historical Cost		6,185,171	16
17	Accumulated Depreciation (book methods)		(13,310,452)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SEE ATTACHED		6,464,337	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 21,583,958	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 899,439	\$ 28,383,497	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 146,855	\$ 1,240,371	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		208,275	28
29	Short-Term Notes Payable		121,473	29
30	Accrued Salaries Payable	138,331	1,448,582	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,579	48,016	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO AFFILIATED CORP.		8,324,617	36
37	BONDS PAYABLE/DEFERRED REV.		653,736	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 290,765	\$ 12,045,070	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		733,800	39
40	Mortgage Payable			40
41	Bonds Payable		15,915,706	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DEFERRED REVENUE		427,471	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 17,076,977	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 290,765	\$ 29,122,047	46
47	TOTAL EQUITY (page 18, line 24)	\$ 608,674	\$ (738,550)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 899,439	\$ 28,383,497	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,957,079	1
2	Restatements (describe):		2
3	ELIMINATION OF AFFILIATED EQUITY	(3,293,094)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 663,985	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(496,974)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) NONE ALLOWED COSTS EXCLUDED	(35,249)	15
16	Other (describe) NET EXP. BOOKED ON CORP. BOOKS	476,912	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (55,311)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 608,674	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,534,904	1
2	Discounts and Allowances for all Levels	(910,750)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,624,154	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	547,361	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 547,361	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,387	12
13	Barber and Beauty Care	95	13
14	Non-Patient Meals	8,658	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 10,140	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,020	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,020	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,187,675	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	968,831	31
32	Health Care	2,019,875	32
33	General Administration	949,582	33
	B. Capital Expense		
34	Ownership	400,875	34
	C. Ancillary Expense		
35	Special Cost Centers	20,426	35
36	Provider Participation Fee	66,153	36
	D. Other Expenses (specify):		
37	ALLOC. OF INDIRECT COST - SCHED. VIII B	258,907	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,684,649	40
41	Income before Income Taxes (line 30 minus line 40)**	(496,974)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (496,974)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number **PINE ACRES CARE CENTER**

0039289

Report Period Beginning: 07/01/1999

Ending:

06/30/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,915	2,082	\$ 51,818	\$ 24.89	1
2	Assistant Director of Nursing	1,915	2,082	46,902	22.53	2
3	Registered Nurses	16,805	18,030	317,962	17.64	3
4	Licensed Practical Nurses	14,414	15,809	279,574	17.68	4
5	Nurse Aides & Orderlies	50,113	54,324	621,740	11.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,838	2,028	25,903	12.77	8
9	Activity Director	1,884	2,080	23,871	11.48	9
10	Activity Assistants	4,337	4,752	37,295	7.85	10
11	Social Service Workers	1,630	1,809	15,074	8.33	11
12	Dietician					12
13	Food Service Supervisor	1,924	2,151	34,558	16.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,098	26,048	217,328	8.34	15
16	Dishwashers					16
17	Maintenance Workers	3,159	3,378	53,454	15.82	17
18	Housekeepers	12,905	14,645	115,628	7.90	18
19	Laundry					19
20	Administrator	1,904	2,080	68,752	33.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,386	10,427	106,705	10.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,744	5,345	84,882	15.88	31
32	Other Health Care(specify)					32
33	Other(specify) <u>BEAUTICIAN</u>	1,685	1,990	19,294	9.70	33
34	TOTAL (lines 1 - 33)	154,656	169,060	\$ 2,120,740 *	\$ 12.54	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	169	\$ 6,648	1-3	35
36	Medical Director	70	5,250	9-3	36
37	Medical Records Consultant	19	1,119	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	14	672	10-3	39
40	Physical Therapy Consultant	N/A	696	10a-3	40
41	Occupational Therapy Consultant	N/A	1,191	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	N/A	83	10a-3	43
44	Activity Consultant	65	3,386	11-3	44
45	Social Service Consultant	30	1,549	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	367	\$ 20,594		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	324	\$ 12,966		50
51	Licensed Practical Nurses	1,296	40,240		51
52	Nurse Aides	4,772	90,567		52
53	TOTAL (lines 50 - 52)	6,392	\$ 143,773		53

XIX. SUPPORT SCHEDULES			
A. Administrative Salaries			
Name	Function	Ownership %	Amount
DALENA KEMNA-KAHN	ADMINISTRATOR	0	\$ 68,752
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 68,752
B. Administrative - Other			
Description			Amount
N/A			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
LIFELINK CORP.	MGMT. FEE		\$ 126,636
LIFELINK CORP.	DATA PROC.		11,548
REINGRUBER & CO.	MEDICARE CONSULTANT		4,681
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 142,865
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 49,962
Unemployment Compensation Insurance			1,082
FICA Taxes			158,793
Employee Health Insurance			260,080
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
LIFE INS / DISABILITY			10,589
PENSION (TSA)			25,170
STAFF MEDICAL EXAMS			8,444
EMPLOYEE RELATIONS/UNIFORMS/ETC.			3,781
RECLASS BEAUTY SHOP			(4,438)
ALLOCATION SCHED. VII-B			15,279
ALLOCATION SCHED. VIII-B			41,725
TOTAL (agree to Schedule V, line 22, col.8)			\$ 570,467
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
NONE			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			4,034
Health Care Worker Background Check (Indicate # of checks performed 92)			644
SUBSCRIPTIONS/REF. PUBL.			1,993
ASSOCIATION DUES			14,244
PROGRAM PROMOTION			4,485
PUBLIC RELATIONS			1,749
ALLOCATION SCHED. VII-B			465
ALLOCATION SCHED. VIII-B			746
Less: Public Relations Expense			(1,749)
Non-allowable advertising			(4,485)
Yellow page advertising			(0)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 22,126
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			2,543
ALLOCATION SCHED. VII-B			169
ALLOCATION SCHED. VIII-B			2,677
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 5,389

* Attach copy of IMRF notifications	**See instructions.
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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number PINE ACRES CARE CENTER

STATE OF ILLINOIS

0039289

Report Period Beginning: 07/01/1999

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Ending: 06/30/2000

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LSN/AAHSA 4,068
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 - 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 828 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 66,153
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? YES For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: ARTHUR ANDERSEN & CO. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. AUDIT HAS NOT BEEN ISSUED.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.